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Subject: Request for Comments (RFA) Number: USAID/Ethiopia RFA-663-14-000002, Notification of Request for comments on potential RFA for implementation of the Integrated Family Health Program (IFHP)-II in Ethiopia

Dear Prospective Applicant:

The United States Agency for International Development (USAID) Mission in Ethiopia is seeking comments on their draft Program Description for the implementation of the Integrated Family Health Program (IFHP)-II in Ethiopia.

Interested/prospective applicants are requested to read the attached program description and provide their comments to caddis@usaid.gov no later than February 7, 2014. Please note that only comments are requested and no applications should be submitted.

Issuance of this RFA does not constitute an award commitment on the part of the Government, nor does it commit the Government to pay for costs incurred in the preparation and submission of your comments. Further, the Government reserves the right to reject any or all comments received.

Sincerely,

Dennis M. Fuentes
Supervisory Agreement Officer
Office of Acquisitions & Assistance
USAID/Ethiopia

PROGRAM DESCRIPTION

INTEGRATED FAMILY HEALTH PROGRAM (IFHP)-II

OVERVIEW

A. Summary

The United States Agency for International Development Ethiopia (USAID/E) Office of Health, AIDS, Population and Nutrition (HAPN) and the Korean International Cooperation Agency (KOICA), hereafter referred to as the "Agencies", Will be seeking services for the implementation of the Integrated Family Health Program (IFHP)-II. IFHP-II aims to increase the utilization of quality health services particularly at the Primary Health Care (PHC) level by improving availability, accessibility of and demand for quality health services, strengthening the decentralized health system and enhancing the management capacity at woreda and Primary Health Care Unit (PHCU) levels in particular. IFHP-II will support the implementation of Government of Ethiopia (GoE) Health Sector Development Program (HSDP) mainly in the area of Maternal, Newborn and Child Health (MNCH), Family Planning (FP), focusing on long acting and permanent methods and integration of FP with HIV/AIDS services, and Reproductive Health (RH). IFHP-II will strengthen the capacity of the health system to effectively use management tools and implement best practices from the regional level down to the community, with particular focus on the woreda and PHCU levels. Furthermore, IFHP-II will support selected activities related to Nutrition, Malaria, and Water, Hygiene and Sanitation (WASH). IFHP-II will build on the platforms and the progress made by the predecessor IFHP, continuing in the same regions, zones, woredas[1] and PHCUs initially, and extending to new woredas and PHCUs as existing ones mature and transition from program technical support. The recipient will be expected to design a degree of flexibility into IFHP II to accommodate opportunities to incorporate and respond to changing needs for support on relevant areas including PMTCT, new initiatives, emerging innovations or GoE policies including the upcoming HSDP V. This activity (IFHP-II) will be jointly funded by USAID and KOICA. While only one application is requested, the successful applicant will sign two different cooperative agreements- one with USAID and one with KOICA.

B. Funding Level, Support and Duration of the Award

The USAID/E funding for this program is $14, 000,000 for the first year. Subject to availability of funding and satisfactory performance of the recipient, this activity may receive further funding of a maximum of $70, 000,000 from USAID/E for a total period of five years. KOICA will fund this five-year activity at the level of $1 million per year. Therefore, the overall combined ceiling for this activity is $75,000,000.

USAID/E's Health, AIDS, Population, and Nutrition (HAPN) Office is organized in four teams: 1) the Health, Population and Nutrition (HPN) team, 2) the HIV/AIDS (President's

1 List of IFHP-I zones/woredas will be provided; additional zones/woredas of KOICA intervention will be determined at a later stage.

Emergency Plan for AIDS Relief [PEPFAR]) team, 3) the President's Malaria Initiative (PMI) Team and 4) the Health System Strengthening (HSS) team. Although this program will be primarily managed by the HPN Team, this comprehensive and integrated program will receive funding from three HAPN Office teams, HPN, PEPFAR, and PMI. It is envisaged that HPN, PEPFAR and PMI will contribute approximately 87%, 6% and 7%, of program funding, respectively, over the life of the project. When preparing the application and addressing the program description outlined below, the applicant should ensure that – to the extent possible – the program's inputs, outputs, and outcomes should reflect these proportional funding levels.

C. Overview of Korea International Cooperation Agency

Korea International Cooperation Agency (KOICA) is in charge of administrating the Republic of Korea's Official Development Assistance (ODA) Programs. KOICA has been activity engaged in development cooperation in Ethiopia since 1995. One of KOICA's main focus areas is the development of the Health sector, especially in Maternal and Child Health and Family Planning as well as prevention of respiratory diseases. KOICA has successfully established a Maternal and Child Health and Family Planning Training Center in Arsi Zone of Oromia. KOICA is currently implementing projects in Maternal & Child Health Care (MCH) and Family Planning (FP) Capacity Building in Tigray Province, Tuberculosis prevention and control in Addis Ababa, and a Project for the national IEC (Information, Education, and Communication) /BCC (Behavioral change communication) and advocacy to promote "Small, Happy and Prosperous family" in Ethiopia. In addition, KOICA is currently supporting the expansion the Youth Friendly Services of IFHP/E2A to additional health centers as part of their IEC/BCC project of MCH/FP.

BACKGROUND

A. Health Status

As Africa's second most-populous country, Ethiopia has a large, predominantly rural, young and impoverished population which is growing by 2.6% annually. Over the last two decades, Ethiopia has made significant gains in family planning and reproductive health indicators as observed in the Ethiopian Demographic and Health Survey (EDHS) 2011. Between 1990 and 2011, total fertility rate (TFR) has declined from 6.4 to 4.8 children per woman and modern contraceptive use has increased from 2.9% to 27%. Despite observed progress the TFR and unmet need for family planning remain high. Rural women bear an average of 5.5 children – more than double that of their urban counterparts - and the unmet need for contraception is 25%. Moreover, no significant change was observed in maternal or neonatal mortality rates between 2005 and 2011. The maternal mortality ratio (MMR) is estimated at 676/100,000 live births. Though Ethiopia officially met its MDG 4 Goal of reducing under-five mortality by 67% since 1990, the rate is still unacceptably high, and neonatal mortality rates (NMR) have remained stagnant since 2005. The EDHS 2011 reported NMR of 37/1000 live births; neonatal deaths accounted for over 60% of infant and 42% of under- five deaths in Ethiopia. Major killers in under-five children include pneumonia, malaria, diarrhea, and severe acute malnutrition. Further, the nutritional status data for children under five years of age indicates that 44% are stunted, 10% wasted, and 29 % underweight. Twenty-seven percent of women of reproductive age are malnourished and 17% are anemic.

The high maternal and neonatal mortality is primarily due to poor quality of, access to and utilization of comprehensive maternal and newborn health services, such as skilled attendance at birth and emergency obstetric care. Factors contributing to these include: shortage of skilled health care providers; unwelcoming providers' attitudes; insufficient supply of medical equipment and consumables; distance to functioning health centers; weak referral systems; limited transport systems, and lack of serviceable roads; out of pocket expenses; cultural norms and traditional health seeking behaviors. The poor socio-economic status of the population, particularly in rural areas, also translates into poor access to safe water, sanitation, housing, food and health services, exposing the most vulnerable group of the population -mothers and children- to various diseases. For example, only 44% of the population in Ethiopia has access to improved drinking water (97% urban and 34% rural) and 21% to improved sanitation facilities (29% urban, 19% rural) that are not shared with other households.

According to the Global TB control report of 2012, Ethiopia ranks 11th among the 22 high TB burden countries with a prevalence rate for all forms of TB of 237 per 100,000 population. HIV prevalence among TB patients is 8%. HIV prevalence is highest in urban and transport-corridor settings, being largely driven by high-risk behavior in most-at-risk populations. The EDHS 2011 shows HIV prevalence of 4.2% and 0.6% for urban and rural areas, respectively. Uptake of PMTCT services remains low due to the underlying low utilization and availability of maternal and newborn services. Almost 98% of pregnant women accessing ANC clinics at health facilities providing PMTCT services are counseled for HIV. However, almost half of pregnant women who have attended ANC do so in sites which are not providing PMTCT services and there is a 23% drop out from counseling to testing and 60% drop out from identification to provision of ARV prophylaxis.

According to the FMoH, in 2010/2011, malaria was the leading cause of outpatient visits and health facility admissions, accounting for 9% of reported outpatient visits and 8% of admissions. Malaria was also among the ten leading causes of inpatient deaths among children under five years of age. In Ethiopia, there are two epidemiologically important malaria parasites, Plasmodium falciparum and Plasmodium vivax. Both require definitive diagnosis due to different treatment approaches. According to the Federal Ministry of Health, 75% of the country is malarious with about 68% of the total population living in areas at risk of malaria, mainly Oromia, SNNPR and Gambella. The transmission of malaria in Ethiopia depends on altitude and rainfall with a lag time varying from a few weeks before the beginning of the rainy season to more than a month after the end of the rainy season. Epidemics of malaria are relatively frequent involving highland or highland fringe areas of Ethiopia, mainly areas between 1,000-2,000 m above sea level.

B. Ethiopian Health Sector Strategy, Structure, Programming and Priorities

1. Overall GoE Strategic Directions and History

Starting in 1996/97, the GoE instituted a series of Health Sector Development Programs (I, II, III, and IV) that serve as the core of Ethiopia's health development, and are geared towards achieving the Millennium Development Goals (MDGs). Since the development of HSDP I, which paved the way for the subsequent HSDP II and HSDP III, the Federal Ministry of Health (FMoH) has formulated and implemented a number of policies and strategies that have provided an effective framework for improving health in the country. The core elements are: democratization and decentralization of the health care system; development of the preventive, promotive and curative components of health care; assurance of accessibility of

health care for all segments of the population; and the promotion of private sector and non-governmental organizations (NGOs) participation in the health sector.

HSDP I and II mainly focused on addressing problems with physical infrastructure. To reach the underserved rural population with preventive and promotive health care, the FMoH also started the Health Extension Program (HEP) during HSDP II (2002/03–2004/05). HSDP III (2005/6- 2009/10) combined acceleration of physical infrastructure, equipping of health facilities and human resources for health development. Central to HSDP III was the use of the community-based health extension workers (HEWs) as a means of improving access to promotive, preventive, and critical curative services for Ethiopians in rural areas. The current HDSP IV (2011-2015) focuses on strengthening quality of care, leadership and governance, and infrastructure and resources.

Ethiopia's "Growth and Transformation Plan (GTP) 2010/11 to 2014/15" guides the country's development in all sectors, with the GoE continuing to take an active role in addressing the country's health challenges. This includes the intention to increase the health budget as a proportion of the total national budget from 5.6% in 2010 to 15% (as per the Abuja Declaration) by 2015 (HSDP-IV). The specific vision and goals of the GoE efforts in the health sector are outlined in the HSDP. Because of the increase in development assistance for health, including from the Global Fund to Fight AIDS, TB and Malaria (GFATM), Presidential Malaria Initiative (PMI) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) as well as the GoE budget to the health sector, the annual per capita expenditure on health has increased from US $7.1 in 2004/5 to $16.1 in 2007/8 (Federal Ministry of Health, 2010). Nevertheless, this is still far below the World Health Organization's (WHO) 2001 recommendation of US $34 per capita expenditure on health, including health systems strengthening (HSS) efforts. Out of the $16.1 per capita expenditure, the contribution of the GoE is estimated to be 22%, while the contribution from external assistance, out-of-pocket expenditures, and the private/NGO sector is 39%, 37%, and 2-3%, respectively.

2. Structure of Health Sector Service Delivery

The Business Process Re-engineering (BPR) of the health sector introduced a three-tier health care delivery system which is characterized by a first level Woreda/District health system comprised of a primary hospital (with population coverage of 60,000-100,000 people), health centers (1/15,000-25,000 population) and their satellite health posts (1/3,000-5,000 population). These tiers are connected to each other by a referral system. A primary hospital, health center and health post form a primary health care unit (PHCU) with each health center having five satellite health posts. The second level in the tier is a general hospital with population coverage of 1-1.5 million people; and the third level is a specialized hospital that covers population of 3.5-5 million.

3. Structure of Health Sector Management

Offices at different levels of the health sector, from the FMoH to Regional Health Bureaus (RHB) to Woreda Health Offices (WorHO), share decision making processes, powers, duties and responsibilities. The FMoH and the RHBs focus more on policy matters and technical support while WorHOs have the fundamental responsibility of managing and coordinating the operation of a woreda health system under their jurisdiction. Regions and woredas manage public health services at their levels. The devolution of power instituted to regional

governments has resulted in the shifting of decision making for public service delivery from the center to the authority of the regions and down to the woreda level.

4. Implementation: Health Extension Program

The HEP is the mainstay of the HSDP and implementation of most of the health programs happen at the primary health care level. The HEP initially was under the woreda administration; however, the GoE has recently restructured the management of the health programs at lower level in which the PHCU (comprising of health center with its five satellite health posts) implements primary health care and the health center in the PHCU is responsible for providing technical and administrative support to the HEWs/HEP. This includes provision of training, mentoring/coaching, supervisions, performance review meetings, etc. There has been considerable progress in rolling out the HEP through strong GoE leadership and support from foreign assistance partners, including the USG. More than 38,000 HEWs (including urban HEWs) have been trained and deployed since the HEP is initiated. The HEP has sixteen packages categorized in four major areas of intervention and service delivery: hygiene and environmental sanitation; disease prevention and control; family health services; and health education and communication. The number of hospitals and health centers has increased over five-fold from 645 in 2004 to 3,372 (3,245 HCs and 127 hospitals) in early 2012; over the same period, the number of health posts increased in the same way to16,048. Another major innovation that occurred under HSDP IV was the implementation of woreda-based planning; which is the development of HSDP implementation plans at the woreda level.

The HEP is based on a package of 16 services, these include:

1. **Disease Prevention and Control**
   a. TB and HIV/AIDS and other STI prevention and control
   b. Malaria prevention and control
   c. First Aid and emergency measures
2. **Family Health Services**
   a. Maternal and child health
   b. Family planning
   c. Immunization
   d. Adolescent reproductive health
   e. Nutrition
3. **Hygiene and Environmental Sanitation**
   a. Excreta disposal
   b. Solid and liquid waste disposal
   c. Water supply and safety measures
   d. Food hygiene and safety measures
   e. Healthy home environment
   f. Control of insects and rodents
   g. Personal hygiene
4. **Health Education and Communication**

5. Priorities of HSDP IV

HSDP IV builds on the achievements of HSDP III, with a focus on improving the quality of service delivery. The plan outlines three strategic themes, or "Pillars of Excellence", with accompanying strategic results and desired outcomes. These themes are:

1) Excellence in Health Service Delivery and Quality of Care;
2) Excellence in Leadership and Governance; and
3) Excellence in Health Infrastructure and Resources.

HSDP IV prioritizes MNCH, prevention of communicable diseases, and HSS. The major vehicle for the implementation of the HSDP IV remains the HEP that promotes primary health care at the community level. HSDP IV also identifies several on-going and new HSS initiatives including the Pharmaceutical Logistic Master Plan (PLMP), the Laboratory Master Plan, the Health Management Information System (HMIS) Reform Scale-up, Public Health Emergency Management, Health Sector Financing Reform and Health Insurance, and the Human Resource for Health (HRH) strategy.

6. Critical Issues

Although the GoE has made tremendous progress in developing state-of-the-art health policies and expanding both its physical infrastructure and availability of Health Extension Workers in rural areas, utilization of key services such as ANC, PMTCT, and labor and delivery services remain particularly low. There are deep rooted and complex factors attached to the low utilization of health services. Health workers, caregivers, community health volunteers (called health development armies), and decision-makers at household and community level require knowledge, supportive attitudes, an enabling environment and skills to encourage key behaviors at the household level necessary to improve health outcomes.

Underlying the health challenges in Ethiopia are poorly developed health systems. While much progress has been made in the last fifteen years in many areas of the health system, the delivery of health services is still seriously undermined by several deep-seated problems:

- Weak management skills at woreda, zonal and regional levels, with limited capacity to ensure PHCU functionality, coverage and quality of services;
- Limited capacity to assure effective functioning of key health systems: HMIS, logistics, human resources, health care financing (HCF);
- A severe health workforce crisis[2], including high turnover and attrition of certain cadres of health workers, and poor systems to deploy, support and retain health workers;
- Supply chain challenges that keep necessary equipment, drugs, supplies and commodities from reaching their destination;
- Weak local financing systems that provide health centers and hospitals with only a fraction of their annual operational budgets;
- Lack of data and poor use of data for decision-making and identifying and solving problems;
- Weak skills and lack of resources needed for program monitoring and evaluation, including integrated supportive supervision;
- Inadequate infrastructure, and

2The WHO recommendation is 2.3 health worker per 1,000 population while Ethiopia's current situation is 1.2 per 1,000 population (the 1.2 includes the HEWs; if we consider the critical masses like OBs/Gyn, GPs, anesthetists, it becomes very sever)

- Untapped potential in the private health sector.

C. USAID/Ethiopia's Health Program

1. Overview

The USAID/Ethiopia Country Development Cooperation Strategy (CDCS) builds on the progress since the last country strategy. A decade ago, the Mission began implementing its last development strategy: "Breaking the Cycle of Famine" which, in the aftermath of the major drought emergency in 2003 that took the lives of tens of thousands of Ethiopian children, was directed at tackling the underlying causes of vulnerability. Much has changed since 2004, and the efforts made to reduce vulnerability have yielded substantial results. The threat of famine has not been completely removed, but enough progress has been made so that USAID can now focus more on helping Ethiopia transform its economy and society toward middle income status.

The GoE's GTP sets very ambitious targets for growth in all sectors, and allocates significant resources to promote development. These ambitious goals reflect this government's sincere efforts to provide health, education and economic growth opportunities to its people. USAID's CDCS builds on the GTP with a concerted investment strategy that aims to help Ethiopia achieve its development goals.

> ***CDCS Overall Goal:*** *Ethiopia's Transformation Accelerated by Strengthening Economic Growth and Resiliency, Social Well Being and Accountability*
>
> ***CDCS Development Objectives:***
>
> 1. *Increased growth with resiliency in rural Ethiopia*
> 2. *Utilization of quality health services produces a more resilient and economically active population*
> 3. *Improved education outcomes for increased economic growth supported by improved enabling environment for sustainable development*

DO 2: "Increased Utilization of Quality Health Services" is based on the evidence that increased utilization of quality, high impact services supported by strong systems is necessary to reduce maternal, neonatal and child mortality and decrease the incidence of major infectious diseases.

The achievement of this DO depends upon the combined success of highly interdependent results that include the key principles of the Global Health Initiative (GHI), that is, a more integrated and coordinated approach both at the supply and demand side for quality health services, and an emphasis on systems strengthening to ensure sustainability. The DO's two main development hypotheses are:

- "Smart" integration of health programs both at the health facility and community levels will help increase efficiencies and effectiveness; and
- Interventions to strengthen health systems will ensure sustainability of results.

2. USAID/Ethiopia's Health Program Integral to GHI

USAID/Ethiopia is focusing its work in MNCH, family planning, nutrition, and HSS to meet Agency goals of ending preventable maternal and child deaths and an AIDS-Free Generation and is aligned with the GoE's new HSDP IV goals and objectives. Projects that support these plans include the Human Resources for Health (HRH), Empowering New Generations in Improved Nutrition and Economic Opportunities (ENGINE), Health Sector Finance Reform (HSFR), Private Health Sector Program (PHSP), HMIS Scale up, various RH/FP and MNCH, Malaria and TB related activities as described below. With PMI funding, support for malaria prevention and control, including diagnosis and treatment, vector control and surveillance is provided to FMoH and regional states. New funding for Neglected Tropical Diseases (NTDs) will allow USAID to address the prevention and control of targeted NTDs in Ethiopia.

USAID is prioritizing key GHI principles including "smart" integration and coordination, a woman- and girl-centered approach, health systems strengthening, a strong focus on monitoring and evaluation (M&E) and a robust country led approach to find more efficient and effective ways of delivering evidence-based assistance.

3. USAID's Experience, Predecessor Projects to IFHP II

From 2003 to 2007, USAID funded the Family Planning/Reproductive Health (FP/RH) project implemented by Pathfinder International, and the Essential Services for Health in Ethiopia (ESHE) project implemented by John Snow, Inc. These programs were followed by the Integrated Family Health Program (IFHP)-I, implemented jointly by Pathfinder International and John Snow, Inc. from 2008 to 2013. While FP/RH and ESHE focused on strengthening and expanding family planning and child survival interventions respectively, both projects also supported the development and strengthening of management and supportive systems for the implementation of health services. The IFHP I project built on these successes and the IFHP II project will further strengthen the regional, zonal, woreda and PHCU management systems and service delivery and health promotion skills and services that these earlier projects supported. Below is a brief summary of the scope and key accomplishments of these projects.

The FP/RH project worked in four regions, Oromia, Amhara, SNNP and Tigray and provided services in the woredas where 57% of the regions' population lived and where there were approximately ten million woman of reproductive age. The overall goal of the project was to introduce and extend RH/FP/MCH knowledge, referrals, services and use, and to address harmful traditional practices (HTP). The project built strategic alliances with a range of dynamic implementing partner organizations (IPOs) and regional governments, and led to new community-based models of family planning service delivery, and increased voluntary commitment and financial support beyond USAID funding.

The RH/FP project was able to contribute significantly to improved RH/FP and related MCH attitudes, knowledge and practice among Ethiopia's largely illiterate rural populations in the four regions where project resources were concentrated. Through the project's support to policy and advocacy for RH/FP at the federal, regional, woreda and community levels, three regions - Oromia, Tigray and SNNP - were able to get RH/FP included in the regional health budgets.

Over the five-year life of the project it reached about 3.7 million new FP clients and generated 3.3 million couple years of protection (CYPs). The 2005 EDHS reported that

modern method contraceptive use among married women had more than doubled from 6.3% to 13.9 % between 2000 and 2005. An analysis of the 2005 EDHS found that "after controlling for their background, women living in areas covered by the Community-based RH (CBRH) program were three times more likely to use contraception than the average Ethiopian woman"[3].

The ESHE project worked in 12 zones of three regions- Amhara, Oromia, and SNNP covering 101 woredas and a population of more than 15 million. ESHE partnered with the FMoH and operated within existing structures of regional health bureaus, zonal health offices, woreda health offices, health facilities, and local communities. The project employed a three-pronged approach that addressed health provider skills, health systems, and family and community health to improve the quality and utilization of high-impact child survival interventions including: the extended program on immunization (EPI), essential nutrition actions (ENA), and integrated management of newborn and childhood illnesses (IMNCI). Key approaches included training to build capacity, mobilizing communities, and encouraging personal behavior change through various communications. In the health sector reform arena, ESHE worked with the FMoH, regional health bureaus, and woreda health offices to institute policy changes aimed at increasing resources available for the health sector, and supported the implementation of health care financing.

ESHE-supported key results included: 54,500 volunteer community health workers trained, reaching more than 12 million people; increased DPT3/Penta3 coverage from 44% to 66% and increased measles immunization from 46% to 64%; early initiation of breastfeeding increased from 46% to 72% and exclusive breastfeeding of children aged 0 to 5 months increased from 59% to 79%; increased Vitamin A supplementation in children 6 to 23 months from 35% to 65%; pregnant women protected from anemia with iron folate supplementation increased from 29% to 46%; and utilization of insecticide-treated bed nets for children under five years of age and pregnant women increased from 2% of households to 52% nationwide. In health financing, per capita budgets more than doubled across ESHE's three focus regions; laws changed allowing health facilities to retain and use their internal revenue; and selection of fee-waiver beneficiaries was systematized and, in one of ESHE-focus regions, more than 1 million beneficiaries began utilizing health services.

The IFHP-I project is a comprehensive and integrated program which the prime partner, Pathfinder International, and John Snow Inc. in partnership with the Consortium of Reproductive Health Associations (CORHA) implement in 306 woredas of the four major regions (Amhara, Oromia, SNNPR and Tigray) and the emerging regions of Benishangul-Gumuz and Somali. IFHP-I benefits approximately 35.2 million people – roughly 40% of the entire population of Ethiopia.

IFHP-I is fully aligned to assist the GoE in realization of its goals as set forth in the HSDP. IFHP-I provides assistance on an integrated package of family planning and reproductive health, maternal, newborn and child health interventions. Investments directly support the HSDP and the HEP with a focus on the delivery of key services and products through a continuum of quality care from the health center to the health post and community level in the rural, peri-urban and hard to reach parts of the country. As a complement to the successful delivery of quality health services, IFHP-I works at the federal, regional, zonal, and woreda levels to enhance government capacity to build and manage the health system. A robust

3 Info extracted from the end of project evaluation report.

monitoring and evaluation system supports knowledge creation and management in order to refine existing program approaches, inform policy dialogue and improve programming of FMoH and other stakeholders.

IFHP-I supports the FMoH in strengthening the HEP to achieve universal coverage for primary health care in Ethiopia. IFHP-I supports an integrated approach to FP/MNCH to create access to a high quality package of basic, evidence based services for women, children and families. Services are offered using key entry-points to the PHCU – the HEWs at health posts and other health service providers at health centers, with the ultimate goal of improving MNCH. Some IFHP-I's achievements from July 2008-September 2012 include: 6,455,436 couple years protection (CYP) generated; 4,021,766 children <12 months received DPT3; 90,280 pregnant women knowing their HIV status; and 945,421children under five received Artemisinin-based Combination Therapy (ACTs).

4. USAID's Other Health Programs

The recipient will need to coordinate activities with other technical assistance programs to the HSDP-IV priorities; assistance provided by USAID/Ethiopia and other development partners to efficiently leverage resources and maximize results. Additionally, many of USAID/E HAPN activities are integrated and cut across the HPN, PEPFAR, HSS and PMI teams and affect the HSDP IV priorities. Primary partners for collaboration are:

- **DELIVER II:** This project, implemented by JSI, supports the MoH and RHBs in strengthening the contraceptive and other essential drug logistics system, and, generally, the implementation of the national Logistics Master Plan. DELIVER brings technical assistance to the MoH and USAID/E implementing partners for commodities security.

- **Contraceptive Commodity Procurement (CCP):** USAID supports GoE with FP commodities worth $ 7,000,000 every year which are currently distributed through IFHP-I.

- **Health Sector Financing Reform (HSFR):** This project, implemented by Abt Associates Inc., supports the implementation of the GoE's Health Care Finance Strategy to: authorize health facilities to retain revenue generated in their facilities; decentralize the management of health facilities to a health management board; expand private wings in public hospitals; improve the waiver and exemptions system; and promote health insurance schemes.

- **National Polio Eradication Initiative:** USAID provides funding for through World Vision/Core Group and World Health Organization.

- **Maternal and Child Health Integrated Program (MCHIP):** This project is implemented in Ethiopia jointly by Jhpiego and Save the Children-US to increase use and coverage of high impact maternal, newborn and child interventions to reduce maternal, newborn and child morbidity and mortality and reduce maternal to child transmission of

HIV infection. MCHIP, being implemented in IFHP-I woredas, complements efforts under IFHP-I particularly through MNH focused interventions like BEmONC, Performance Quality Improvement (PQI), Postpartum FP (IUCD), and Essential Newborn Care (ENC).

- **Improving Demand, Access and Use of key MNCH interventions:** This project is implemented by JSI/L10K in selected woredas. The L10K project is primarily funded by the Bill and Melinda Gates Foundation; USAID support complements the project through implementation of iCCM and selected MNH interventions including basic emergency obstetric and newborn care (BEmONC). This project aims at increasing access to and utilization of selected maternal, newborn and child health services and contributes towards the reduction of maternal, newborn, and child morbidity and mortality to accelerate the achievement of Millennium Development Goals related to maternal and child mortality.

- **HMIS and M&E Scale-up:** This project is implemented by John Snow Inc./MEASURE EVALUATION with the following objectives: to assist the SNNP RHB implement the new HMIS/M&E; assist FHAPCO to refine and scale-up the Community Information System (CIS) in SNNPR and nationwide; and establish a computerized HMIS/M&E data processing and reporting system at national, regional, zonal and woreda levels.

- **Systems for Improved Access to Pharmaceuticals and Services (SIAPS**): is a cooperative agreement mechanism implemented by Management Sciences for Health (MSH), started in 9/23/2011 and ends in 9/22/2016. The goal of the SIAPS Program is to assure the availability of quality pharmaceutical products and effective pharmaceutical services to achieve desired health outcomes. The SIAPS result areas/objectives include improving governance, building capacity for pharmaceutical management and services, addressing information needed for decision-making in the pharmaceutical sector, strengthening financing strategies and mechanisms to improve access to medicines, and increasing quality pharmaceutical services.

- **Private Health Sector Program (PHSP)**: is a five year bilateral program implemented by Abt Associates and ends on Sept 2014. The goal of PHSP is to enhance the role of the private health sector in expanding access to affordable public health services, especially HIV/TB , FP, Malaria and STI services through improved government stewardship , private sector networking and financing, and enhanced consumer health knowledge. The program is designed to achieve the following results: (i) establishment of a supportive policy environment for the private health sector; (ii) enhancement of both geographic and financial access to packages of essential health services through the private sector; (iii) sustained improvements in the quality of these services; and (iv) increased demand for quality services by informed, proactive consumer populations.

- **Support for International Family Planning Organizations (SIFPO)-FP Social Franchising Project:** Implemented by Marie Stopes International, the project aims to increase availability of quality FP services in 79 selected woredas of the Tigray and Oromia regions through strengthening and supporting 180 private clinics to provide comprehensive FP services in partnership with outreach teams and government health facilities.

- **Strengthening Ethiopia's Urban Health Program** (**SEUHP):** Implemented by JSI, the goal of SEUHP is to improve the health status of the urban population in Ethiopia by reducing HIV/TB-related and maternal, neonatal and child morbidity and mortality and the incidence of communicable diseases. SEUHP will build on achievements of the predecessor USAID-supported Urban Health Extension Program (UHEP) which supported the training, deployment and management of urban health extension workers. As such, SEUHP will be largely a community based program targeting vulnerable population groups through household level health interventions, including health education, basic health services (immunization, postnatal care, TB screening) and improved referral between facility and non-facility level health services. Reduction of maternal, neonatal and child mortality through promotion of facility delivery, follow-on postnatal care, and other reproductive health services is a key objective of SEUHP. The SEUHP will be implemented in 40 urban areas in the four major regions and Dire Dawa, Addis Ababa and Harar. IFHP II will closely collaborate with SEUHP to avoid activity overlap especially in peri-urban areas.

- **Empowering New Generations to Improve Nutrition and Economic Opportunities (ENGINE):** Implemented by Save the Children Federation, Inc., in partnership with Tufts University, Valid International, Jhpiego, JHU CCP and Land O Lakes, the project aims to improve the nutritional status of women and young children through sustainable, comprehensive, and coordinated evidenced-based nutrition interventions in 100 woredas in Oromia, Amhara, SNNPR and Tigray Regions. There is a nutrition technical working group (TWG) to coordinate FtF nutrition activities and support integration of nutrition into other FtF projects. The TWG is instrumental in avoiding duplication of project efforts, in identifying opportunities for collaboration, sharing technical expertise and assisting other projects to overcome challenges.

- **TB CARE I:** This project is a USAID global field support TB mechanism implemented through the partnership of KNCV, MSH and WHO. This national level support to TB program activities aims to strengthen Government's technical and management capacity and coordinate the overall TB control efforts in the country. It primarily supports the health system at federal and regional levels including regional laboratories.

- **HEAL TB:** This project supports case detection, treatment, and diagnosis targeting 691 health facilities (23 hospitals and 668 health centers) in 199 woredas found in five zones in Oromia and five zones in Amhara. Management Sciences for Health (MSH) is the prime partner, with All African Leprosy, TB Rehabilitation, Research and Training Center (ALERT), Program for Appropriate Technology in Health (PATH), and Kenyan Association for the Prevention of Tuberculosis and Lung Diseases (KAPTLD) as sub-awardees.

- **PEPFAR:** PEPFAR is implemented jointly by USAID, Center for Disease Control (CDC) and the Department of Defense (DoD). Any potential HIV programming under IFHP II will have to be closely coordinated across agencies. USAID's supported activities under PEPFAR focuses on the following areas: prevention of mother-to-child transmission of HIV; counseling and testing; provision of condoms and other forms of prevention; basic palliative care; care and support for orphans and vulnerable children; partnerships with government entities; and procurement of commodities. In addition, PEPFAR provides significant support for HSS, including training and other capacity-building activities; supply chain logistics; infrastructure development including construction and renovation of health facilities; support for Ethiopia's health management information system; health care finance reform; and supporting an expanded role for the private healthcare sector. Together with its USG PEPFAR partners, USAID provides significant support for HRH including providing HIV/AIDS-related pre-service training to doctors, nurses, midwives, health officers, pharmacists and other health professionals and supports extensive in-service education for health professionals including medical doctors, health officers, nurses, lab and pharmacy technicians, case managers and volunteers.

- **PMI**: As in the other 17 PMI focus countries, PMI's support in Ethiopia focuses on malaria prevention and control to reduce morbidity and mortality due to malaria through proven preventive and therapeutic interventions, including diagnosis and treatment, insecticide-treated bed nets (ITNs), indoor residual spraying (IRS), surveillance and M&E, operational research and SBCC[4]. Given USG and GoE priorities, there may be new interventions overtime and the applicant is expected to respond accordingly. PMI currently has 11 implementing partners in Ethiopia including IFHP-I, through which the support in above-mentioned areas is provided. Whilst originally PMI support primarily focused on Oromia Regional State, since 2011, support has increasingly been provided to the national level, supporting the MOH national malaria prevention and control efforts. Accordingly, a couple of PMI's implementing partners have supported in-service training, for example in malaria diagnosis, malaria case management, or malaria epidemic detection and response.

4 http://www.pmi.gov/countries/mops/fy12/ethiopia_mop_fy12.pdf

D. Other Development Partner Support for Health Programs (MNCH and FP/RH)

There are several other donors and agencies including United Nations agencies (UNICEF, WHO and UNFPA) supporting the improvement of MNCH and FP/RH in Ethiopia. Their support takes several forms including demand and supply side support. The successful applicant is expected to partner with all relevant stakeholders at each level.

PROGRAM DESCRIPTION

A. Scope and Expected Results of the Integrated Family Health Program (IFHP)-II

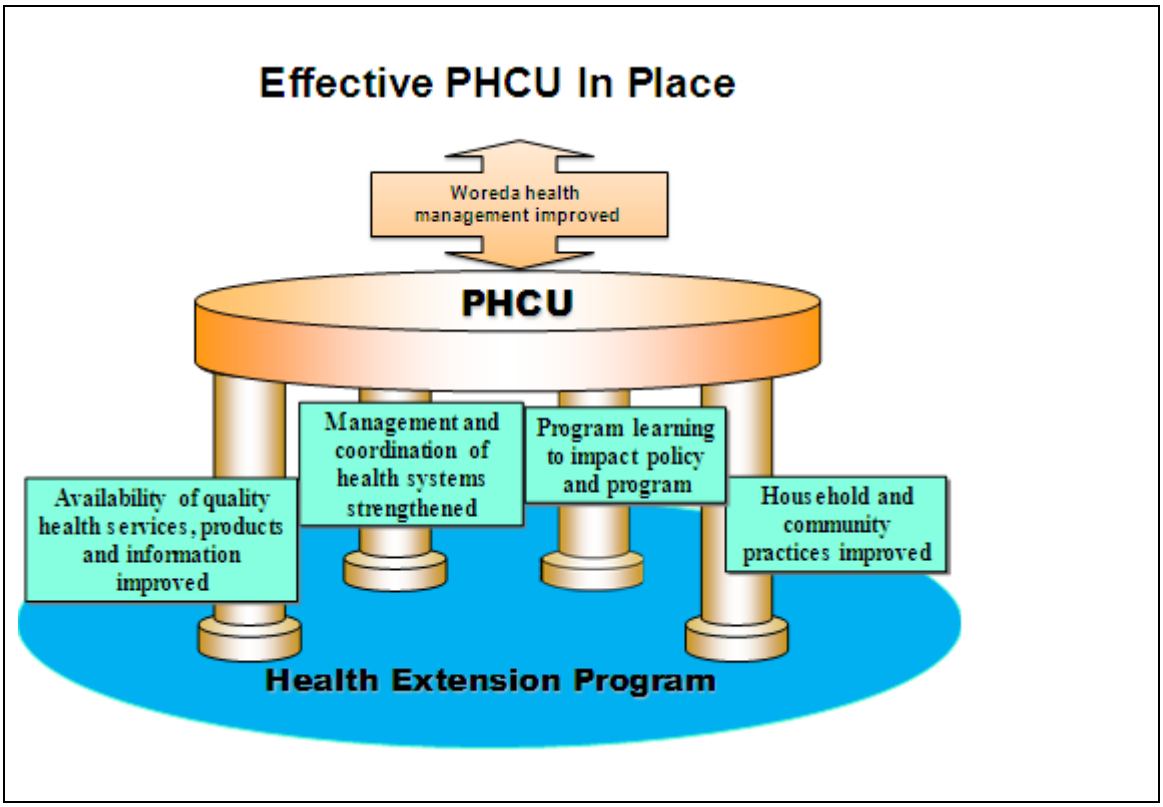
Applicants must present a technical approach and management plan that will: achieve the expected results; respond to the scope for the program; take into account and reflect understanding of the cultural, political, economic, and geographic environment; demonstrate creativity and innovation in approaching challenges and anticipated problems; and strive towards greatest public health impact per dollar invested through efficiencies, coordination, and leveraging. Applicants can consider applying in partnership with sub recipient/s if they believe this is the best strategy in effectively and efficiently implementing a program of such complexity.

IFHP-II will support the implementation of the HSDP IV mainly in the area of MNCH including PMTCT, FP focusing on long acting and permanent methods, and the integration of FP with HIV/AIDS services and RH. Further, IFHP-II will support selected activities related to Nutrition, Malaria and WASH. It will primarily focus on the support of the GoE's initiative of the PHCU. The foundation for the PHCU is the HEP and as such the IFHP-II will continue supporting the HEP, building on the achievements of the predecessor IFHP. IFHP-II primarily focuses on high impact interventions which are critical in ending preventable maternal and child deaths.

IFHP-II aims at increased utilization of quality health services through strengthening the decentralized health system and enhancing the management capacity of the woreda and PHCU levels in particular. It will also support a life cycle and continuum of care approach at household/family, community and health facility levels through provision of selected evidence- based and high impact packages of services to bring about improved health behaviors and high utilization of services. The following picture depicts the framework for the IFHP-II with four major result areas.

Finally, in each of the IR areas described below, the recipient will be expected to design a degree of flexibility into IFHP II to accommodate opportunities to incorporate new initiatives, emerging innovations or GoE policies including the upcoming HSDP V.

Integrated Family Health Program (IFHP)–II Activity Framework



B. Overall Approach and Geographic Scope

IFHP II is designed to work in partnership with the GoE to strengthen the PHCU, in particular, with an emphasis on supporting availability of quality health services, products and information; management and coordination of health system; production and utilization of program based evidence; promotion of health seeking behaviors; and improvement of household and community practices. IFHP-II is also designed to enhance the capacity of the GoE with particular focus on the woreda and PHCU. While addressing this, the applicant should come up with new and more practical cost-effective approaches to provide technical assistance to the GoE in a way that won't create a parallel system. Furthermore, this support system should have a benchmarked sustainability component that will allow for graduation of a majority of woredas upon completion of the IFHP II life cycle. The applicant is expected to have a thorough understanding of the changing landscape related to MNCH and FP/RH both at global and national levels.

As a flagship program, IFHP II will need to coordinate and clearly collaborate with relevant USG supported and other donor funded programs. It is expected to play a facilitative and catalytic role in supporting the GoE particularly at lower levels to mobilize and leverage resources particularly in the areas of HSS. While other specialized projects will be leading the expansion and strengthening of several health systems, the applicant will coordinate with these efforts, with a focus on their implementation at woreda and PHCU levels. It will not, however, replace assistance already provided by USAID through other mechanisms or other

donors. It should come up with more practical and effective ways of coordination with these specialized USG funded and other donor supported projects.

All USAID projects, and especially those such as this one that are designed to increase access to services for underserved populations, include a focus on gender and people living with disabilities. All project activities should be examined with these "lenses" to ensure that no one is denied services because of their gender or a disability. Specific gender-related activities, such as those addressing Harmful Traditional Practices (HTPs) (i.e. early marriage, female genital cutting (FGC) and others) should be included in a successful application. While it is beyond the scope of this program to increase physical access to all health facilities for disabled peoples, program activities should ensure that they do not actively discriminate against the disabled and should include sensitization for health management and staff so they can identify and reduce barriers themselves.

The IFHP-II will build on the platforms and the progress made by IFHP-I, continuing initially in the same regions, zones, woredas[5] and PHCUs, and extending to new woredas as existing ones mature and transition from program technical support, while at the same time ensuring sustainability of results achieved in those graduating woredas. As more established woredas graduate, they will receive less technical support but will still need some level of financial resources from the program. The applicant is encouraged to come up with innovative and aggressive approaches for geographic scale up and graduation including direct grants to graduating woredas. The program will bring new woredas on board for technical and financial support through the life of the program. Criteria for graduation will need to be established in partnership with USAID, GoE, RHBs and key stakeholders. However, the applicants are expected to propose the set of criteria that they will employ for graduation and can use the sustainability assessment[6] done under the predecessor program as one of their tools for setting criteria. These criteria will form the basis for woreda-level assessments and future decisions about graduation. Effective graduation will be a metric against which project success will be measured.

C. Expected Results

1. End of Project Results

Building on progress made under the IFHP and its predecessors, and by coordinating with other health and HSS efforts of the GoE and development partners/ projects, by end of project period, the recipient is expected to achieve the following Life of Project (LOP) results. Progress toward these results will be marked by attainment of benchmarks along the way. These benchmarks will be proposed by the applicant as part of the Activity M&E plan and Transition Plan to be submitted with the application, and refined, as needed, shortly after program start-up. The LOP results reflect the inter-relatedness of the four sets of program IRs that focus on services, systems, behavioral change and learning.

- Quality and coverage of priority health services improved in supported PHCU facilities as evidenced by increased utilization and client satisfaction
- Program-supported Regions, Zones, Woredas and PHCUs have health management, health systems, and health services functioning according to GoE standards. It is

5 List of IFHP-I zones/woredas will be provided with the RFA; additional zones/woredas of KOICA intervention will be determined at a later stage.
6 The assessment report or a link to it will be provided with the RFA.

anticipated that by the end of IFHP-II, approximately 50 percent of supported woredas graduate and transition from technical assistance.

- Demonstrated behavioral change in supported communities evidenced by increased demand and utilization of health services.
- Program learning is shared and applied at a larger scale to increase performance of health management, health systems and health services within and between PHCUs, woredas, zones and regions, beyond the IFHP-II supported areas.

Essential to implementing and adapting new or updated tools, procedures and processes within health management and health service systems is a robust learning agenda, with lessons learned from successful approaches institutionalized within organizations and sites, shared with others, and scaled up to improve system functionality and health outcomes. The applicant should propose a learning agenda that will contribute to improving efficiency and effectiveness of management, health, and service delivery systems, as well as to increase and sustain demand, coverage, quality and utilization of essential health services at facility and community levels.

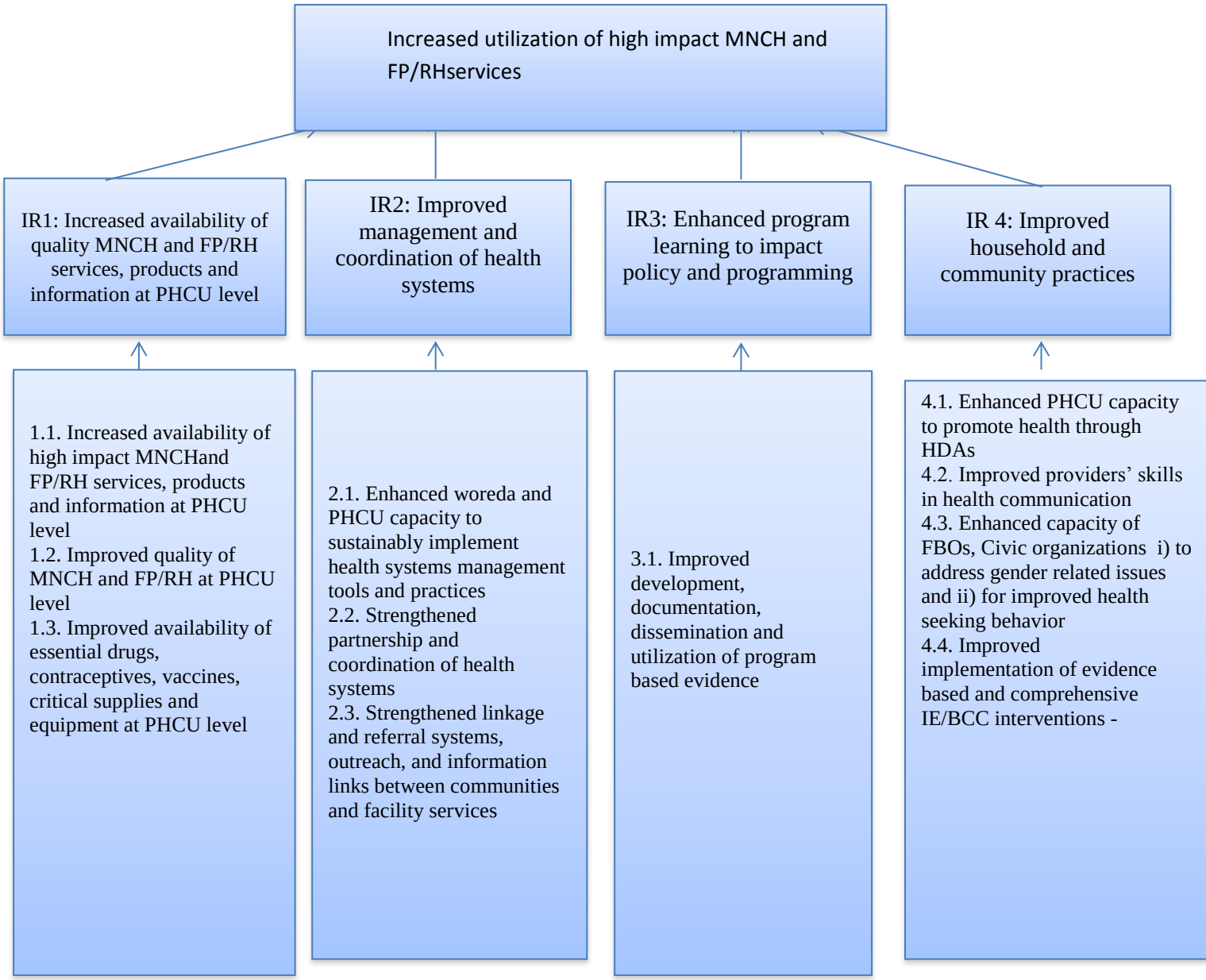
To accomplish the LOP results the applicant should achieve four major results as described below. These results are interrelated; that is, working to implement the system strengthening result may generate topics and questions that contribute to the development of program research and/or small studies and/or other activities that constitute achieving the "learning agenda" result. Similarly, it is anticipated that strengthening the PHCU service delivery may also generate topics and questions for the learning agenda. The results of the studies will affect the systems for service delivery and their management as well as the building of woreda and PHCU capacity. Strengthening the health system, program learning and health promotion all contribute to improvement in quality of health services.

IFHP-II will contribute significantly to the data required for several indicators outlined in the USAID/Ethiopia Performance Monitoring Plan (PMP). Indicators are selected from a standardized global list of indicators and are reported on annual basis. In addition to the PMP indicators, while process indicators will also be used, for the purpose of evaluation, the IFHP-II will identify key outcome-oriented indicators that can be measured at years 3 and 5 in the overall project cycle. These outcome indicators should be linked to each of the 4 results described below. Additional outcome/impact indicators representing overall program progress (i.e. not necessarily linked directly to one of the four results) may be proposed.

Applicants should propose integrated practices, products and services as appropriate, keeping in mind the program will be funded primarily from the population/reproductive health and MCH budget. It is anticipated that additional funds will be provided through PMI and PEPFAR for selected activities. While project activities are integrated, different funding sources may have specific reporting requirements. For example, of the anticipated 14 million USD annual budget for the project, 1 million USD per year is earmarked as Water, Sanitation and Hygiene (WASH) monies, which are linked to the Paul Simon Water for the Poor Act and activities and indicators must meet reporting requirements for that act. Similarly, PEPFAR monies for HIV/AIDS related activities have a specific reporting requirement.

2. Intermediate Results and Sub-results

Results Framework



IR1: Increased availability of quality MNCH and FP/RH services, products and information at PHCU level

Sub-Results

1.1. Increased availability of high impact MNCH and FP/RH services, products and information at PHCU level

1.2. Improved quality of MNCH and FP/RH at PHCU level

1.3. Improved availability of essential drugs, contraceptives, vaccines, critical supplies and equipment at PHCU level

Intent Statement

IFHP II will enhance the GoE's capacity to deliver an integrated package of high impact family health services at the primary health care level, which extends from health post to health centers and primary hospitals. This will include delivery of family planning services focusing on long acting and permanent methods; integration of HIV/AIDS and FP/RH services; focused antenatal care; nutrition support; labor and delivery care; PMTCT; support and care of the newborn; child health; adolescent and youth reproductive health care; and malaria prevention, treatment and epidemic detection and response. The applicant should propose effective models to expand and maximize delivery of health services ensuring that it remains government owned.

The program will give emphasis to the improvement of the quality of family health services at the primary health care level. There are many quality and performance improvement approaches/models being used in the country and beyond. The applicants should select and/or modify an existing package that best fits the Ethiopian context. The quality improvement package should be one that provides a sustainable solution to the prevailing gaps in quality of health care in Ethiopia and should be a model that ministry counterparts at each level understand and apply without heavy oversight or long-term external engagement. Focused support for the delivery of quality services will be placed on the primary health care level: HEWs at health posts and clinicians working at the health center and primary hospital level.

IFHP II is expected to work in close collaboration with the GoE and key partners at each level to ensure that essential drugs, contraceptives, vaccines, critical supplies and equipment at PHCU level are available in an uninterrupted manner. USAID will continue to support the procurement of contraceptives; however, this support may decline as other sources of support can be leveraged.

1.1. Increased availability of high impact MNCH and FP/RH services, products and information at PHCU level

The GoE has identified several high priority/impact clinical interventions to be strengthened and expanded throughout the country in order to realize the targets set in HSDP IV. The applicants should describe how they would enhance GoE's capacity to deliver an integrated package of these priority/high impact family health services at the primary health care level.

- **Maternal and Newborn Health (MNH).** The HSDP IV has made maternal and newborn health one of the top priorities and the FMoH has identified six objectives in the MNH Roadmap for Accelerating the Reduction of Maternal and Neonatal Morbidity and Mortality in Ethiopia, each with its own strategies: 1) to strengthen the capacity of individuals, families, and communities to improve maternal and neonatal health; 2) to increase skilled attendance during pregnancy, childbirth and postnatal period; 3) to scale up the provision of Basic and Comprehensive Emergency Obstetric and Neonatal care; 4) to increase use of key newborn services and practices by households; 5) to increase access to access to Family Planning information and services at all levels; and 6) to strengthen the Health System Management and Partnership to Deliver Effective and Efficient MNH Services. IFHP II will support the GoE to implement this roadmap and realize its set objectives.

  Many HEWs have been trained in clean and safe delivery; however, they are not considered to be skilled attendants. Greater effort will be needed to increase pregnancy, birth and postpartum care with skilled providers, especially at health centers and primary hospitals, and to increase the competency of their staff to provide basic emergency obstetric and newborn care (BEmONC) emphasizing safe delivery, use of Partograph, active management of third stage of labor (AMTSL), immediate and appropriate care of the newborn, and postpartum follow up within two days of birth. Primary hospitals are supposed to provide Comprehensive Emergency Obstetric and Newborn Care (CEmONC) in addition to the basic MNCH services they provide. HEWs are encouraged to promote and increase women's utilization of skilled birth attendant services at PHC facilities.

  Currently the FMOH has issued Implementation Guideline for Community Based Newborn Care with the aim of reducing newborn (and child) mortalities. This entails scaling up of community based MNH services including introduction of newborn sepsis management. This initiative requires strengthening of the PHCU approach and improvement of the linkage between health posts and health centers. It will help to further improve facility based newborn care. IFHP II will support the GoE in its effort to improve newborn health as per the national guideline.

- **Child and Maternal Nutrition:** Malnutrition continues to be a major public health problem in Ethiopia and is estimated to contribute to one-third of all infant and child deaths. Micronutrient deficiencies are widespread, with specific concerns around iodine, zinc, and iron. The 2011 DHS reports that 44% of children are anemic and only 26% of children 6-23 months eat fruits and vegetables rich in Vitamin A. The 2011 DHS also reports that 27% of women of reproductive age are malnourished and 17% are anemic. The HSDP IV aims at improving the nutritional status of mothers and children through various interventions including support for the Enhanced Outreach Strategy (EOS) currently transitioning to HEP with Targeted Supplementary Food (TSF), improving health facility nutrition services, strengthening community based nutrition (CBN), improving micronutrient interventions, and reinforcing the importance of integrated infant and young child feeding counseling by HEWs and other community level workers or

volunteers. Nutrition is a key component of the Health Extension Package. The IFHP–II will continue its support to the HEP to increase its effectiveness in improving critical child feeding practices like exclusive breastfeeding and appropriate complementary feeding, providing micronutrients to the most vulnerable groups and promoting a more nutritious diverse diet for pregnant and lactating women. IFHP-II with will work with the GoE and collaborate with other partners such as the USAID Feed the Future partners at national, regional and woreda levels to improve the nutritional status of women and children.

- **Child Health:**

  - **Integrated Management of Newborn and Childhood Illnesses (IMNCI).** The focus of IMNCI services is malaria, pneumonia and diarrhea, the three largest killers of children under five. At the health post, HEWs are implementing integrated community case management (iCCM) of simple cases of childhood malaria, pneumonia, severe acute malnutrition, and diarrhea through early detection and treatment. Severe cases are referred to or present at the health center for treatment and observation. The FMoH has prioritized strengthening the skills of health center staff to correctly diagnose and appropriately manage and treat childhood illnesses.

  - **Immunization:** Increasing immunization coverage through strengthening the routine EPI and campaigns is among the focus areas of HSDP IV. IFHP-II will support the GoE in its effort to meet the HSDP IV targets for immunization. The GoE recently introduced Pneumococcal Conjugate Vaccine (PCV) and has a plan for introduction of Rotavirus vaccine. IFHP-II will support this effort to ensure smooth implementation of the new vaccine introductions. There are other partners supporting the GoE on immunization and IFHP-II will collaborate with these so that the GoE addresses the challenges of meeting the immunization targets.

- **Prevention of Mother to Child Transmission (PMTCT) of HIV/AIDS:** To address the low coverage and high drop-out rates of PMTCT services for HIV-positive mothers and their infants, the FMoH has developed an accelerated plan for PMTCT in Ethiopia. The focus of the plan was on demand creation, site expansion, and improvement of quality of PMTCT services. The country has now endorsed Option B+ PMTCT strategy where all HIV-positive pregnant women will be eligible for HAART upon diagnosis. The country has also already launched the Elimination of Mother to Child Transmission of HIV (e-MTCT) strategy. In the current USG PMTCT strategy, the USG is primarily working through Regional Health Bureaus to scale up quality PMTCT services in high HIV/AIDS burden areas. IFHP-II will support the FMoH strategy by focusing its efforts on creating demand for PMTCT services and improving FP/HIV integration at the primary health care level. Demand creation will primarily occur through the HEP, with HEWs

sensitizing women and their families during their ANC visits about the importance of doing at least one ANC visit at the health center where both the pregnant mother and her partner should be screened for HIV and other sexually transmitted diseases. Prong II of the global PMTCT strategy focuses on increasing access to family planning for HIV positive women. During IFHP-I, health centers decentralized FP counseling and provision, making services available in the ANC area, youth friendly consultation rooms and VCT sites. In IFHP-II supported health centers, Health Centers will continue to provide quality reproductive health services and ensure that these quality services are available in each of these locations.

While the current scope of IFHP-II PMTCT activities is limited to demand creation and FP/HIV integration, the applicant should still be ready to engage in the provision of comprehensive PMTCT services as necessary to shift or align with changing USG/GoE priorities. If these priorities change, IFHP-II would need to ensure that comprehensive services are provided for pregnant, laboring, and postpartum women with a focus on HIV Counseling and Testing services and leveraging the existing MNCH services to identify, link and refer women to appropriate PMTCT services. This will include an emphasis on ensuring all HIV Exposed Infants (HEIs) get tested for HIV based on the national guidelines.

- **Family Planning/Reproductive Health:**

  - **Long-Acting and Permanent Methods (LAPM) of Family Planning.** To allow women's and couples' greater choices of contraceptive methods, the FMoH has prioritized the introduction and scale up of long-acting and permanent methods, including Intrauterine Contraceptive Devices (IUCDs), implants, tubal ligation and vasectomy. HEWs are being trained to insert a one-rod implant (Implanon) at the health post, but removals are performed by a trained provider at the health center, or during outreach visits to the health post. The FMoH would like to expand access to IUCDs, including immediate postpartum insertion, as well as tubal ligation and vasectomy at facility level. IFHP-II will build on prior USAID investments in FP programs and support the GoE in expansion of LAPMs. IFHP-II will also support efforts on integration of RH/FP and HIV/AIDS services.

  - **Adolescent Reproductive Health:** the HSDP IV also aims at improvement of adolescent and youth health. The MoH has already developed strategies, guidelines, and standards for adolescent and youth reproductive health and made efforts for the implementation of these. Given the fact that over 63% of Ethiopia's population is under 25, addressing the RH needs of young people becomes more critical than ever. IFHP-II will support the GoE in implementation of these strategies/guidelines.

- **Malaria:** In addition to the above MNCH and FP/RH services, IFHP-II will work on select areas of Malaria. HSDP IV sets targets to reduce malaria case fatality and incidence rates among children under five and adult populations and has identified key initiatives to realize these targets. The applicant will coordinate and collaborate with other actors working on malaria to help the GoE achieve its targets. Specifically, IFHP-II will support early diagnosis and treatment of cases including management of severe malaria through building the capacity of health care providers at the PHCU level; work with other partners to ensure availability of essential commodities for the diagnosis and treatment of malaria; support malaria interventions under the HEP including ICCM; support integration of malaria prevention and case management in MNCH and behavior change communication activities to ensure utilization of malaria services; and build the capacity of woredas and PHCUs for effective epidemic preparedness, early detection and response.

- **WASH**: The vast majority of Ethiopia's population lacks adequate access to safe water and proper sanitation facilities. According to the WHO/UNICEF Joint Monitoring Program (JMP)[7] report of 2013, only 49% of the population in Ethiopia has access to improved drinking water and 21% to improved sanitation facilities that are not shared with other households. Moreover, adherent to correct hygiene behaviors, such as washing hands at key times , safe storage of drinking water and point of use water treatment , is extremely low. The GoE aims to increase access to improved water supply in rural communities to 98%, universal latrine coverage and to increase utilization of improved sanitation facilities to 84% by 2015(GTP/HSDP IV). Building on the GOE's successful program, the applicant is expected to propose innovative approaches for integration of WASH into MNCH and FP/RH activities.

- **Tuberculosis (TB):** TB in children and women is an important cause of morbidity and mortality. The diagnosis of TB in children especially is quite challenging and requires integration of TB and TB/HIV services within all relevant MNCH services. The primary role of MNCH services would be to undertake suspect identification and referral to TB and TB/HIV treatment facilities. Working closely with other USAID-funded TB projects, IFHP-II will play an important role in early case detection and reducing the financial and transportation burdens of referring TB suspects from the health posts to health centers.

1.2. Improved Quality of MNCH and FP/RH Services at PHCU level

Improving quality of health services is central to increasing the utilization of these services and thus improving the health status of the population. In principle, higher quality services attract more clients and increase service utilization, while meeting the needs of providers and benefiting health programs overall.

7 WHO/UNICEF: Progress on Drinking Water and Sanitation, 2013 Update.

Quality is a multidimensional concept. WHO (2006) suggests that a health system should seek to make improvements in six areas or dimensions of quality. These dimensions require that health care be: effective, efficient, accessible, acceptable/patient centered, equitable and safe. Each level of the health system has a role to play in improving the quality of health care. Communities and health service users also have critical roles in identifying their own needs and preferences, and in managing their own health. To ensure that there is optimal satisfaction by clients, there needs to be active participation of the community in every aspect of quality improvement.

HSDP IV has put improving the quality of health care at all levels of the health system (both management and service delivery) as one of its priority areas. It has plans to realize improvement in the quality of health services through implementation of tools, manuals and standards that have been developed as part of Business Process Re-engineering (BPR). BPR defined quality structures, quality planning, quality performance measurement, quality improvement activities, mechanisms for involving actors, evaluation of programs, quality service delivery and health management at all levels of the health system. Implementation of the Performance Monitoring and Quality Improvement Standard Operating Procedure is also meant to ensure adherence to standards.

In line with the HSDP IV and the GoE's priorities, IFHP-II will focus on improving the quality of MNCH and FP/RH services at the PHCU level. It will closely work with the FMoH/Medical Service Directorate and other partners to ensure that the health facility reform guidelines address each component of MNCH and FP/RH services and the guidelines are translated into practice. It will ensure adherence to the standards and guidelines for all MNCH and FP/RH services at PHCU level, even as they are updated. Supporting the FMoH to ensure that there are updated/evidence based clinical guidelines addressing each of the major MNCH issues, and that these guidelines are translated into practice at the PHCU level, will be part of the quality improvement process. The program will support the FMoH and its regional and sub- regional counterparts so that PHCU facilities, in line with those guidelines, will have operational, observable performance standards that the facilities can use as tools to measure their performance related to MNCH and FP/RH. PHCU service delivery sites should have internal processes for monitoring quality, reviewing performance, and improving adherence to standards for priority health services, as well as cross-cutting interventions, such as infection prevention and waste management.

The program will ensure that there is a sustainable and formal system/mechanism in which the community is involved in oversight of health service quality. It will support the PHCU facilities to engage the communities at all stages of the quality improvement process. It will mainly focus on building the capacity of the PHCU so that they can address quality issues on their own in a sustainable manner. It will also support them to leverage resources in addressing the gaps identified in the process of quality improvement.

In implementing quality improvement activities, IFHP-II will be the major program that will address providers' skills gaps related to MNCH and FP/RH, though it should collaborate with other programs to leverage resources. As in-service training will be one of the main instruments to develop providers' skills and improve their performance, IFHP-II should follow the GoE's guidance on in-service training for health workers. It should ensure that this is done in a system that will sustainably support delivery of quality services. IFHP-II should also closely work with the FMoH and partners, particularly with the national technical working group (TWG) working on health workers' in-service training, to ensure

standardization, effectiveness, efficiency and sustainability of training activities. Overall, IFHP-II will emphasize "leverage and collaborate" versus duplicate.

As new health services are introduced, protocols and guidelines updated, and staff, managers and supervisors rotate in and out of PHCU service settings, there is a continual need to improve knowledge, skills and competence at various levels. The service delivery systems should be able to adapt to these changes, to ensure that staff are competent to carry out a variety of clinical and non-clinical functions according to GoE standards at PHCU hospitals, health centers, health posts and in the community.

IFHP-II will also support the PHCU to integrate MNCH/FP/RH and HIV/AIDS services for improved effectiveness and to avoid missed opportunities.

1.3. Improved availability of essential drugs, contraceptives, vaccines, critical supplies and equipment at PHCU level

Availability of essential drugs, contraceptives, vaccines, supplies and equipment is critical for the delivery of quality MNCH and FP/RH services at PHCU facilities. USAID, through various mechanisms, supports the GoE's national supply chain system to ensure that there is uninterrupted supply of safe, effective, and quality medicines. USAID will continue to support the procurement of contraceptives, though this support may decline as other sources of support can be leveraged. IFHP-II is expected to work in close collaboration with the GoE key partners, at each level, to ensure that essential drugs, contraceptives, vaccines, critical supplies and equipment at PHCU level are available in an uninterrupted manner. The recipient will work with other USAID supported mechanisms to project and monitor stock levels, and ensure reporting. It will enhance the capacity of the PHCU to leverage resources including the health care financing initiative, to address gaps in health commodities.

Illustrative Indicators for IR 1

- Couple years of protection (CYP) in USG-supported programs
- Contraceptive prevalence rate (CPR): Percent of women aged 15-49 who are using a modern method, disaggregated by age (15-24 and 25-49)
- Percent of women who deliver with skilled birth attendants
- Percentage of children who received DPT3 (Pentavalent) by 12 months of age from USG-supported programs
- Number of people trained with USG funds disaggregated by sex and thematic area (malaria,, FP/RH, MNH, Child Health and nutrition, Gender/HTPs, Adolescent Reproductive Health (ARH), etc.)
- Number of children under five receiving ACTs (Artemisinin-based Combination Therapy)

- Number of people in target areas with first-time access to improved drinking water supply with USG assistance
- Number of people in target areas with first-time access to improved sanitation facilities with USG assistance
- Number of TB suspects referred through IFHP-II

The applicant is expected to come up with original indicators as appropriate along with incorporating required as well as a selection of illustrative indicators. Emphasis should also be given to quality improvement/performance measures/indicators which should at least include outcome measures (e.g. mortality and complications), process measures (e.g. clinical and operational compliance) and satisfaction measures (e.g. patient/client, family members, and staff).

IR2: Improved management and coordination of health systems

Sub-Results

2.1 Enhanced woreda and PHCU capacity to sustainably implement health systems management tools and practices

2.2 Strengthened partnership and coordination of health systems

2.3 Strengthened linkage and referral systems, outreach, and information links between communities and facility services

Intent Statement

Effective and efficient health systems are critical to assure coverage and quality of essential health services. Regions, zones, woredas, and PHCUs need to effectively and efficiently lead and manage the implementation and improvement of health systems to ensure uninterrupted delivery and coverage of quality health services. IFHP-II will strengthen the capacity of the health system to effectively implement management practices that resonate from the regional level down to the community, with particular focus on the woreda and PHCU levels.

Each level of the health structure, from region down to PHCU, should have the institutional capacity to implement, improve, adapt and ensure that essential management and health systems are functioning effectively and efficiently, and to ensure continuity of performance when staff leave, and new staff arrive. Leaders and managers at all levels should have the capacity to identify and resolve problems related to the functioning of systems, as well as ensure the coverage and quality of essential health services.

The program will support woreda-based planning and work with concerned partners to ensure that the planning gives greater attention to critical areas such as HRH planning, budgeting, logistics, HMIS, supervision, performance reviews and quality improvement interventions. The program is also expected to enhance the capacity of each level of the health system with

a focus on woreda and PHCU to effectively and efficiently implement supervision in a sustainable manner. It will ensure that there is a system that will use findings from supervisions in fora such as performance reviews, etc. in order to improve the quality of service provision. The applicant will play a catalytic role in support of TWG meetings at each level to ensure that there is harmonization with core plans and to maximize the use of available technical, material, and financial resources. In particular, the program will enhance the capacity of the woreda and PHCU level of the system to problem solve and crisis manage. Support for woreda based planning should enable the health system at these levels to anticipate and address critical issues and thus avoid major problems/crisis. However, they need to be supported so that they will have the capacity to deal with such issues when they arise.

While other specialized projects will be leading the expansion and strengthening of several health systems, through joint work planning, the applicant will coordinate with these efforts, with a focus on their implementation at woreda and PHCU levels, in ways that support the overall functioning of the management and service delivery functions. IFHP II will support woreda-level management of existing national programs and health sector reform activities. The applicant will also be expected to support government entities to conduct a mapping exercise of all the partners in the health sector that will stem from woreda-based planning.

The program will address those systems which are key to ensuring increased coverage, improved quality, and enhanced health seeking behaviors for priority health services and build the institutional capacity of woredas and PHCUs to improve and institutionalize these systems. The applicants are also expected to introduce proven interventions that will strengthen the referral linkage between the facility based and community based services.

2.1 Enhanced woreda and PHCU capacity to sustainably implement health systems management tools and practices

The GoE has prioritized key management tools and systems, with a focus on strengthening performance at woreda and PHCU levels. The applicant will describe how they will build and sustain capacity at each level of the health system to enhance the performance, efficiency and effectiveness of these management systems, and management functions, as needed.

- **Woreda-Based Health Sector Planning (WB-HSP).** The FMoH's goal of "one plan, one budget, one report" provides a framework for this management process. Strengthening this evidenced-based planning and budgeting system builds capability at the woreda level for analysis of systems functioning and constraints. It integrates financial inputs from all sources- government, donors, projects and NGOs into a budget that funds priority areas. WB-HSP puts responsibility, accountability and power to manage health programs with woredas and PHCUs. The WB-HSP serves also as an input to regional and then national level development of annual work plans and budgets. These are output-based work plans that provide information for the National Annual Review Meeting and Regional Health Bureau Review Meetings and serve as a basis for performance monitoring throughout the year.

- **Integrated Supportive Supervision (ISS).** ISS is a participatory, problem-solving approach to improving staff, management and system performance by documenting and sharing findings through verbal and written feedback and planning for follow-up actions. Checklists enable supervisors to cover a broad range of management, service delivery and system issues, identify gaps, enhance staff performance, jointly develop solutions to alleviate problems, improve overall performance and monitor the effectiveness of the actions through joint follow up visits.

- **Performance Review Meetings.** Performance review meetings are held monthly at health center and health posts, and quarterly at woreda/zonal health office levels, to review ISS, HMIS, and other reports. The woreda health offices, zonal health departments, and regional health bureaus review progress against planned goals, compliance with health policies, system functioning, utilization of health services, and problems affecting performance. Strategies are developed for overcoming problems and an agreed-upon action plan is outlined at the end of each meeting.

- **Supporting community based services**: PHCUs need to monitor and enhance the coverage and quality of integrated health services at the community level. Under the HEP, HEWs at the health post level of the PHCU provide a package of sixteen services. In addition, HEWs work with and mentor community health volunteers (known as Health Development Army) to improve household behaviors and practices, as well as health seeking behaviors. Per the GoE policy, implementing partners can not directly work with the HDAs. HEW supervisors at the PHCU Health Centers are part of the integrated supportive supervision team who work with HEWs to review and improve their performance in all aspects of implementation of the HEP package of services, and to identify and solve problems with system-related issues that impact the coverage and quality of health services. The applicant will describe how they will build the capacity of woredas and PHCUs over the life of the project to take on full responsibility for monitoring and enhancing the coverage and quality of the integrated package of health services at the community level.

2.2 Strengthened partnership and coordination of health systems

While other specialized projects will be leading the expansion and strengthening of several health systems, the applicant will propose how they will coordinate with these efforts, with a focus on their implementation at woreda and PHCU levels, in ways that support the overall functioning of the management and service delivery functions. For these systems to function optimally they need information from, and implementation by, woreda and PHCU staff and managers, and conversely, the woredas and PHCUs rely on receiving and benefitting from the processes of these systems functioning according to standard. The applicant will describe the types of activities to be carried out at the woreda and PHCU levels for each of these systems, such that they will strengthen the functioning of these systems, and are essential to

improvements in the functioning of woreda and PHCU management and service delivery functions.

- **Logistics and medical supply distribution.** At the woreda and PHCU levels, all health services are dependent on a reliable supply of essential drugs, contraceptives, vaccines, supplies and commodities to provide quality health services. Conversely, the logistics system depends on LMIS information from service delivery sites and woredas on their forecasted needs as well as their utilization/consumption data. IFHP-II will collaborate with other partners and specialized projects to ensure availability of contraceptives, essential drugs, vaccines and commodities.

- **HMIS**: Reliable, complete and timely data is needed for effective decision-making. The GoE is focused on reforming and scaling up HMIS with the objective of generating reliable data for decision making at all management levels. IFHP-II will coordinate and collaborate with other partners and specialized projects to ensure successful implementation of the reformed HMIS at the PHCU level. The applicant is expected to coordinate with others in addressing identified HMIS issues and play complementary roles but not replace efforts of others. IFHP-II will also support the use of local data for decision making.

- **Human Resources for Health (HRH)**: Existence of competent and motivated personnel is key to ensuring coverage of quality health services. HSDP IV gives priority to improving HRH and the GoE has developed an HRH Strategy that frames its priorities. USAID supports implementation of the HRH strategy through various mechanisms. The applicant will work closely with the GoE and partners to assure that there are adequate and competent staff to provide the priority services at PHCU and woreda level.

- **Community and other health financing schemes**: The GoE has adopted policies and reforms to help address funding and financing shortfalls. Under the HSFR program, the GoE is undertaking various reforms including establishment of local revenue retention schemes at health centers and hospitals with the aim of ensuring that adequate resources are mobilized from internal and external sources; that there is equitable resource allocation, greater improvement in the resource absorptive capacity and decreased wastage of resources. The reform also includes establishing social health insurance for formal sector employees, including the public sector, and designing, piloting and scaling up of community-based health insurance schemes in selected woredas. IFHP-II will support PHCU facilities to ensure effective and efficient utilization of the local revenue retention schemes and mobilize and leverage resources for improved quality service provision. It will also support the PHCU and HEP in particular in promoting community participation in insurance schemes.

2.3 Strengthened linkages and referral systems, outreach, and information links between communities and facility services

To ensure an integrated package of services along a continuum of care from household to primary hospital level, referral linkages between the community and facility based services needs to be strengthened. A strong and functional referral system is particularly critical in saving the lives of mothers and children and/or preventing disabilities in times of medical emergencies. The applicant is expected to work with relevant actors to ensure that there is an effective referral linkage between community and facility services. It will also support the formalization and regulation of referrals between the levels within the PHCU. The service delivery system should ensure that each level of the PHCU routinely and regularly gets feedback from the referring facility and uses this opportunity to learn from and teach lower levels.

IFHP-II will enhance the capacity of the HEP/PHCU to work with the HDA and communities in order to improve recognition of the need for referral at household and community levels. However, the recipient will not work directly with the HDA. IFHP-II will also work to improve the recognition of the need for referral at health post and health center level by HEWs and health workers, respectively. IFHP-II will strengthen the mechanisms for communication and feedback between levels of care within the PHCU ensuring that the facilities have and use the referral forms including feedback slips. Integral to strengthening of the referral linkage is the need to strengthen proper management of complications/referred cases at referral sites. IFHP-II will also address this as part of a quality improvement process. IFHP-II will support each level of the PHCU to implement outreach services in order to back up the lower level service provision. The applicant is expected to collaborate with each level of the MoH, other sector offices and key partners to ensure that the GoE establishes a sustainable solution to transport problems related to referrals for medical emergencies especially for maternal and child cases. As part of the IR-3 of this program description, IFHP-II will test community solutions to address transportation, communication and financial barriers at the community level.

Support to strengthen the health system will be built on USAID interventions made to date focusing on models and approaches that can be effectively scaled up to ensure maximum coverage and ownership by the GoE. This will require the development and implementation of innovative strategies for graduation and transition from more mature focus areas to new focus areas.

Illustrative Indicators for IR 2

Applicants are expected to come up with a comprehensive set of indicators. Examples of some indicators that could be used include:

- Number of USG-assisted service delivery points (SDP) experiencing stock-outs of specific tracer drugs disaggregated by drug and SDP
- Percent of Woreda HOs using HMIS data for planning and decision-making
- Percent of supported Health Posts receiving 3 supervision visits in the last quarter

- Percent of IFHP-II-supported woredas that submit their annual work plan before the deadline

IR3. Enhanced Program Learning to Impact Policy and Programming

Sub-Results:

3.1. Improved development, documentation, dissemination and utilization of program based evidence

Intent Statement
The HSDP-IV puts operational research in health as critical part of its M&E strategy and it is very crucial to identifying priority health and operational problems by producing evidences for planning and decision making for improving health services. Given that it is comprehensive/integrated program and targets the PHCU, IFHP-II presents an opportunity to learn and generate evidence from its implementation for improved health care provision with in the PHCU and ultimately improved health outcomes. More importantly, a detailed learning agenda and evidence-based research allow lessons learned to be shared outside of the IFHPII-supported woredas, increasing the project's potential impact. The learning agenda of this program should be ambitious and work toward real and sustained improvements across the entire health care system. The applicant must present a plan for identifying and using information from analyses, small and larger-scale studies and other operations research to inform program and policy for improved maternal and child health outcomes. It should also demonstrate how it would ensure that there is a strong and sustained institutional approach for developing programmatic oriented/guided research agenda related to FP/RH and MNCH.

The program interventions and approaches will be evaluated with well-implemented, systematic, commonly accepted operations and evaluation research methodologies. These activities will generate technically defensible evidence useful for advocacy and will influence health services policy and programming adjustment and expansion. The applicant will be mandated to collect, analyze and manage a knowledge base to determine what works, and identify best or promising practices. This will include global and Ethiopian best practices and lessons learned in the areas of family planning, child survival, maternal and neonatal health.

3.1.Improved development, documentation, dissemination and utilization of program-based evidence

The HSDP-IV considers operations research including innovative approaches and improving evidence based decision making as critical part of its M&E strategy. Operations research is also part of the major activities in the Roadmap to reducing maternal and neonatal deaths. Program learning will be an integral part of IFHP-II as this will provide objective evidence for improvements in systems and services which are often accompanied by new interventions, innovations, and ways of doing business. Some of these may have already been tested and proven effective in other countries or settings within Ethiopia, and could be applied or adapted for use within this program. The aim is to improve the effectiveness and functioning of systems along with health outcomes, and to do so in ways that improve efficiencies to achieve the same or better results. The applicant will propose a learning

agenda for testing innovations and interventions designed to achieve improvements in capacity, efficiency and effectiveness of woreda and PHCU systems and services, and describe how successful approaches will be institutionalized within the woreda and PHCU functioning.

In addition to testing innovations, the applicant is expected to propose key learning agenda items focusing on known bottlenecks in MNCH and RH/FP service provisions. The proposed learning agenda items may be revised depending on the USG and GOE priorities. Applicants should indicate how they will ensure ownership by each level of the health system. Illustrative interventions might include but not limited to:

- Direct financing of woredas to address budget gaps
- Adjustments in management systems that may reduce costs, yet assure effectiveness and improve sustainability
- Approaches to expanding the technical assistance reach of program support to non-Program woredas and PHCUs at minimal additional cost
- Creative solutions to water and power shortages at health facilities
- Community solutions to referrals/transport of obstetric emergencies

Throughout the life of IFHP-II, as results of assessments, studies and evaluation become available, it is important to share the findings of what worked, as well as what did not work, and to apply/adapt successful approaches to achieve improvements across program-supported sites, within Ethiopia, with other donors/projects, and the international community more broadly. The applicant will describe approaches for sharing findings from the learning agenda, and how these successful interventions will be applied/adapted and taken to scale within and beyond program-supported sites. The applicant is expected to work with the GoE to develop and share evidence from key learning agenda topics that contribute to the global evidence on the identified topics. GOE and USAID must be engaged and involved with regards to sharing or publishing reports related to GOE lead programs. It is also important to note that these interventions must be cost-effective and cost-realistic as to allow the GOE to eventually fund the follow-on activities in a sustainable way.

Illustrative Indicators for IR 3

Specific indicators will be determined based on key program-related issues identified but the following are illustrative indicators:

- Number of new GOE-initiated learning agenda activities projected in USG-supported woredas.
- Number of woredas reviewed and placed on funding graduation plan
- Number of former IFHP woredas that have graduated from IFHP-II technical assistance.
-

IR 4: Improved Household and Community Practices

Sub-Results

4.1. Enhanced PHCU capacity to promote health seeking behaviors

4.2. Improved providers' skills in health communication

4.3. Enhanced capacity of FBOs, Civic organizations to address HTPs and for improved health seeking behavior

4.4. Improved implementation of evidence based and comprehensive IE/BCC interventions

Intent Statement

Reaching individuals, families and communities through social and behavior change communication (SBCC) interventions is an essential function of the HEP. SBCC approaches, including IEC materials and community health education and mobilization should be of high-quality, provide correct and consistent information, be appropriately targeted to the populations they are intended to reach, and in line with GoE standards and recommended practices. They should inform about personal and communal health practices that prevent diseases, as well as encourage early and appropriate health seeking behaviors for preventive and basic curative services for maternal and child health care, family planning, and treatment of illness.

Recently the GoE embarked on a new initiative for its interventions on health communication and promotion. This initiative, called the HDA, employs a 1 to 5 networking approach in which one graduated model family volunteers to work with five other households in order to facilitate their graduation as model families. In order to be considered a model family, the household must demonstrate at least 75% of the model behaviors/components of the HEP package.[8] These HDAs are in turn supervised by another person who tracks the progress of 30 families. Through their focus on health-related BCC, the health extension workers are integral to the success of individual families and villages and are involved at all stages of the model family and village process.

IFHP-II support will mainly focus on enhancing the capacity of the HEP and the PHCU to ensure evidence-based IEC/BCC approaches are employed to increase knowledge of healthy behaviors and practices, improve health seeking behaviors as well as use of health services at the facility level. These efforts will address the determinants of relevant behaviors including harmful traditional practices and cultural norms in order to improve health-seeking behaviors/practices, and establish antenatal care, institutional delivery and family planning as cultural norms.

While most of the health education and health promotion activities are conducted by the HEWs and community volunteers, it is also an essential function of the woreda and PHCUs

8 FMOH, Health Extension Program Implementation Guideline, Page 12-13,Revised, October 2012, Addis Ababa

to support and strengthen the capacity of HEWs to manage and implement high quality BCC interventions. The applicant will describe how they will strengthen both the capacity of the management and service delivery systems to strengthen BCC as an essential health component, and to strengthen the capacity of woredas and PHCUs to manage and strengthen health promotion and prevention messages, materials, and communications approaches, and to achieve improvements in individual, household and community practices and health seeking behaviors.

While the major focus of IFHP-II is support for the PHCU for improved health seeking behaviors, working with FBOs and civic organizations (women and youth associations) is critical for the desired behavioral change in relation to RH/FP and MNCH and also for addressing gender issues in general and HTPs in particular. Applicants are expected to propose a plan on how effectively they will ensure that these groups are engaged for the support of the overall SBCC activities with in the PHCU.USAID/Ethiopia is intending to award a specialized SBCC project whose focus will be capacity building and coordination. The recipient of IFHP-II is expected to actively collaborate with the SBCC project to ensure SBCC messages are coordinated and effective.

Illustrative Indicators for IR 4

Applicants should identify indicators that show a direct relationship from community mobilization interventions to actual behavior change and use of health services and/or products. The applicant is also encouraged to suggest indicators to measure improved community capacity to sustain health improvements. The following are some of the illustrative indicators:

- Percent of births receiving at least 4 antenatal care (ANC) visits during pregnancy
- Percentage of women who are informed of signs of pregnancy complications among those who have received ANC
- Number of early marriages deferred /cancelled
- Number of religious and community leaders trained on Gender, HTPs, GBV
- Percent of children under five who slept under an ITN the previous night
- % of households practicing hand washing with soap or its substitute at critical times.
- % of villages in USG supported woredas that are Open Defecation Free

ADDRESSING GENDER ISSUES

The health of women and girls in Ethiopia is precarious, and the poor quality of health services, especially in the rural areas, only exacerbates the problem. Women enjoy little independent decision making on most individual and family issues, including the option to use birth control, whether to give birth in a health facility, or to seek the assistance of a trained provider. Harmful traditional practices – female genital cutting, early marriage and childbearing, gender-based violence (domestic violence is so accepted that, according to the

2011 Demographic Health Survey, 68% of women interviewed believed there are justifiable reasons for a husband to beat his wife), in addition to forced marriage and wife inheritance – impose additional negative impacts on Ethiopian women's reproductive health and lives.

Maternal and child mortality can be improved with better services but as important is the age and health of the mother at time of birth. The harmful practices of early marriage, FGC and other types of violence against young girls are major impediments to the improvement of maternal and neonatal health. Equally important is allowing girls to attend and complete their schooling. The best way to protect girls is through an all-of-society approach that advocates for the elimination of these deleterious practices.

Throughout Ethiopia, the burden of care falls disproportionately on females, regardless of age. Women are expected to care for sick members of the household, and young girls are much more likely than their brothers to be withdrawn from school to support the household. Educational attainment, literacy, exposure to mass media and employment are critical contributors to women's empowerment and exert considerable influence on their position in the household.

MNCH and RH/FP programs need to involve boys and men as well. Male gender norms influence a range of RH behaviors. Evidence suggests that interventions that examine, question, and change male gender norms are more effective in improving outcomes than those that merely acknowledge or mention gender roles. RH/FP and MNCH programs could exert greater and more sustainable impact by adopting approaches that explicitly attempt to transform male gender norms. The applicants are expected to come up with innovative and effective ways of addressing male norms to ensure a sustainable program outcome.

USAID Ethiopia commits to address gender inequalities across its development objectives. In addressing gender issues in IFHP-II, the recipient is expected to do the following activities:

- Conduct a gender analysis at all stages of the program cycle
- Address identified issues in program design; detail strategies in work plan
- Collect sex-disaggregated data and set gender-sensitive indicators
- Monitor and evaluate gender issues
- Report on progress in closing gaps, creating opportunities, negative impacts avoided, and emerging issues

MONITORING AND EVALUATION

A. Performance Monitoring and Evaluation

Monitoring and reporting of results is a key element of USAID and KOICA programs. The agencies seek data and information to improve performance and effectiveness as well as to inform planning and management decisions. Accurate and timely monitoring will enable the program to adapt to changing conditions and make mid-course corrections as necessary. Data must also be available to demonstrate program impact. IFHP-II will formulate a rigorous monitoring and evaluation (M&E) system that will identify staffing requirements, technical support and a routine data collection system. As quality data is critical to the success of the program, the M&E system should ensure the quality of data.

Indicators and targets for each result and sub-result should also measure how the program will strengthen management and coordination of systems and services, and implement a

related learning agenda and apply results in ways that advance overall performance and sustainability. Indicators should have widely shared definitions and allow aggregation of results across the entire program.

Specific indicators and targets for achievement of program objectives and each of the four results and sub-results will be developed by the recipient and submitted as part of the overall Activity M&E plan. Applicants are encouraged to propose additional program indicators in addition to the ones provided in the document that will measure program progress and impact more effectively. The successful applicant will submit a detailed implementation plan including the Activity M&E plan within 60 days following the award. The program will work closely with USAID/E to refine indicators and performance targets for each technical area covered.

Although KOICA is a key contributor to IFHP-II, for expedience and in an effort to avoid duplication of oversight, USAID will be responsible for the overall implementation of the activity. KOICA staff though may serve as Activity Mangers for key portions of the program. A USAID Agreement Officer's Representative (AOR) will be designated by USAID/E's Agreement Officer shortly after the award is made. The AOR will monitor and evaluate the recipient's overall performance against deliverables and expected performance using agreed-upon indicators. Joint USAID/KOICA semi-annual performance reviews (SARS) will be conducted through the life of the program based on USAID's SARS calendar. The agencies may also conduct management reviews of work progress during the life of the program. USAID will conduct Data Quality Assessment (DQAs) for selected indicators annually to ensure that quality data is collected.

The program will conduct end line survey. The program will use the findings of the end line survey conducted under its predecessor program (IFHP-I) and other existing data sources including EDHS 2011 as baseline to gauge its progress towards set targets.

USAID will conduct an external midterm evaluation of the program 24-30 months after the award is made. .

B. M&E and Reporting Requirements

The recipient will adhere to all reporting requirements listed below. All reports as required under substantial involvement shall be submitted by the due date for approval of the USAID AOR designated by the Office of Assistance and Acquisition. Additional reports requiring review and clearances, when necessary, are listed under each requirement. The recipient will consult with the AOR on the format and expected content of reports prior to submission. The recipient should always be ready for revision in program indicators and reporting requirements.

1) Plans

a) *Activity Monitoring and Evaluation Plan (M&E plan):* The proposed Activity M&E plan for the entire period of performance data must be submitted in the initial work plan(five-year implementation plan).

b) *First year work plan:* The first year work plan shall be submitted by the recipient within 60 days of the award. The first work plan to be submitted will not necessarily

be for a full year or may be for more than a full year, depending on the start date of the agreement.

c) *Environmental mitigation and monitoring plan (EMMP):* IFHP-II should address potential hazards to the environment pertaining to the implementation of the program. The implementing partner is expected to submit a five year EMMP with the initial five year implementation plan and regularly report on the compliance status of the activity as per the approved EMMP.

The work plan, IEE, EMMP and Activity M&E plan will be subject to the written approval of the AOR and USAID/E Mission Environmental Officer (MEO).

2) Annual Work Plan (2 copies)

The program needs to submit subsequent annual work plans in the time frame given by the USAID/E Office of Acquisition and Assistance according to a format agreed upon by USAID and the program, to be submitted to the AOR for approval. The work plan will be developed in collaboration with KOICA and other USG implementing partners. The EMMP needs to be submitted together with annual work plans for approval.

3) Progress Reports (2 copies)

The recipient shall submit an updated report on progress toward agreed performance targets every three (3) months and annually, based on the Activity M&E plan to be developed by the recipient in collaboration with USAID. Quarterly and annual narrative reports are expected to be delivered to USAID/Ethiopia within four weeks after the end of the quarter and 45 days after the end of the Fiscal Year respectively. Each report should include information on activities completed during the preceding period in all regions, zones and woredas, as well as any support provided at the national level. The report must also include the following: 1) progress achieved towards benchmarks, tangible results and explanation of quantifiable output of the programs or projects, if appropriate and applicable; 2) reasons why established targets were not met; and 3) analysis and explanation of cost overruns or high unit costs (recipients must immediately notify USAID of developments that have a significant impact on award-supported activities). Further, notification must be given in the case of problems, delays, or adverse conditions which materially impair the ability to meet the objectives of the award. These notifications must include a statement of the action taken or contemplated and any assistance needed to resolve the situation. The standard and agreed upon indicators should be addressed in all progress reports. The progress report should also include any progress made on the learning agenda; the implementing partner is expected to share separate reports of individual studies conducted under this award. A template for the reports will be provided by the AOR. Additional reports focusing on the KOICA intervention zones may be requested by KOICA; this will be stipulated in the final agreement between KOICA and the successful applicant.

4) Financial Reports

Financial reporting requirements will be in accordance with 22 CFR 226. Quarterly financial reports are expected to be submitted to USAID/E within four weeks after the end of the quarter. The report should include a summary of finance, a pipeline analysis of funds obligated, funds expended, expenses accrued and funds remaining by program areas. Additional reports focusing on the KOICA intervention zones may be requested by KOICA; this will be stipulated in the final agreement between KOICA and the successful applicant.

5) Success Stories

At least two one-page success stories on program activities shall be submitted to USAID/E in the quarterly report. Please review USAID guidance on "success stories' available at http://www.usaid.gov/stories/. Additional reports focusing on the KOICA intervention zones may be requested by KOICA; this will be stipulated in the final agreement between KOICA and the successful applicant.

6) Demobilization Plan

At least 6 months prior to the completion date, the recipient shall submit a demobilization plan for the AOR's approval. A property disposition plan, plan for the phase-out of in-country operation and delivery schedule for all required reports or deliverables along with a timetable for completing all required actions should be included in this plan.

7) Final Report (2 Copies)

USAID requires, 90 days after the completion date of this Cooperative Agreement, that the recipient submit a final report which includes an executive summary of the recipient's accomplishments, targets not achieved, lessons learned, challenges and conclusions about areas in need of future assistance; an overall description of the recipient's activities and attainment of results and sub-results by region, as appropriate, during the life of the Cooperative Agreement; an assessment of the progress made toward accomplishing the LOP results and expected results and sub-results, and overall project impact; analysis of the significance of these activities; important findings and recommendations; and a fiscal report that describes use of funds expended under this award. See 22 CFR 226.51. The recipient is expected to submit, with the final report, a list of all the studies conducted during the LOP and a compilation of all the publications/materials produced on the learning agenda. An additional final report focusing on the KOICA intervention zones may be requested by KOICA; this will be stipulated in the final agreement between KOICA and the successful applicant.

C. USAID Management

The Cooperative Agreement will have one AOR who will be supported by KOICA and a USAID Technical Management Team from within the HAPN Office. The AOR will work in collaboration with AORs, CORs and Activity Managers for other projects whose activities are complementary to the program, including bilateral projects and field support (centrally-managed) projects. The AOR, supported by the USAID/KOICA Technical Management

Team, will provide oversight of the Cooperative Agreement. USAID will retain substantial involvement for activities conducted under the Cooperative Agreement. USAID and KOICA will regularly meet with program senior leadership and staff to track program and activity design, implementation, and evaluation; and conduct annual or semi-annual management reviews and quarterly budgetary analyses.

D. Management Reviews and Evaluations

The annual work plan and annual report will form the basis for a joint annual management review by the Agencies and program staff to review program directions, achievement of the prior year work plan objectives, major management and implementation issues, and make recommendations for any changes as appropriate.

At any time during program implementation, the Agencies may conduct one or more evaluation(s) to review overall progress, assess the continuing appropriateness of the program design, and identify any factors impeding effective implementation. The Agencies will use the results of the evaluations to recommend mid-course changes in strategy, if needed, and to help determine appropriate future directions. Site visits may occur any time after the initial six month period. For the first few months, the Agencies will meet regularly with the program staff to ensure that start-up activities are on track.

SUBSTANTIAL USAID INVOLVEMENT

USAID shall be substantially involved during the implementation of this Cooperative Agreement in the following ways:

1) Approval of the recipient's initial and annual work plans, and all modifications, which describe the specific activities to be carried out under the Agreement;

2) Review of technical progress reports and financial reports;

3) Approval of key personnel and any changes;

4) Approval of monitoring and evaluation plans. The Agencies will be involved in monitoring progress toward achievement of the LOP results and the four results and sub-results during the course of the Agreement and in monitoring financial expenditures;

5) Approval of all international travel; and

6) Approval of sub-awards, transfers or the contracting out of any work worth more than $100,000;

7) As appropriate, other monitoring as described in 22 CFR 226.

The Cooperative Agreement for the project will be managed by the Health Team of the USAID/Ethiopia Mission's Health, AIDS, Population and Nutrition (HAPN) Office. The (cooperative) agreement with KOICA, focusing on the KOICA intervention zones will be managed by KOICA/Ethiopia with the consultation of health specialists of KOICA/Ethiopia and KOICA HQ.

KEY PERSONNEL

The key staff positions for the IFHP-II will include:

i. Chief of Party

ii. Deputy Chief of Party/Technical Director

iii. Administration and Finance (Operations) Director

iv. Senior M&E and Research Advisor

The applicants are encouraged to have Ethiopian key personnel who meet or exceed the qualifications described below.

Chief of Party: The Chief of Party must have at least a master's degree in a relevant discipline and at minimum 15 years of demonstrated experience in designing and managing complex integrated health programs in developing countries. S/he is expected to have the strategic vision, leadership qualities, depth and breadth of technical expertise and experience, professional reputation, management experience, interpersonal skills and written and oral presentation skills to fulfill the diverse technical and managerial requirements of the program description. S/he should also have demonstrated experience interacting with other projects, host country governments at all levels, and international agencies. Strong background in RH/FP and management of health systems in developing countries is advantageous.

Deputy Chief of Party/Technical Director: The Technical Director should have a minimum of 10 year experience and the required educational and technical background to provide the state-of-the-art technical advice in the full range of technical areas covered under IFHP-II. S/he should have substantial experience in designing, implementing and managing health projects of such complexity and size in general and RH/FP and MNCH projects in particular in developing countries. S/he should have a demonstrated capacity to liaise and negotiate/interact with key stakeholders including other donors, implementing partners and host country government on the thematic areas under this RFA. Strong background in management in decentralized health systems in developing countries is advantageous.

Administration and Finance (Operations) Director: The admin and finance director must have the required educational background in management related skill areas and a minimum of 15 years of progressive experience with international organizations (implementing partners) in the area of management and finance. S/he should have senior level experience with projects of such complexity and size. S/he should have a solid background in working with diverse cultural setups specifically in African and Ethiopian culture, including local partner financial management. S/he should have excellent communication skills.

M&E and Research Advisor: The M&E research advisor must have a firm command of M&E and research issues related to strengthening management, health and service delivery systems, as well as coverage, quality and utilization of public health services. S/he shall have substantial (5-8 years) experience developing and supervising monitoring and evaluation efforts for multi-faceted health programs in developing countries, and an advanced degree in demography/statistics or a related field. S/he must have demonstrated analytical skills and experiences in utilization of data for problem identification, problem solving and decision

making. S/he must have demonstrated ability to undertake and supervise operations research and disseminating findings, including application of learning into programs. Strong writing and presentation skills in English for reporting on program and study results are essential.

The Technical Review Committee reserves the right to request interviews with the proposed Chief of Party as part of the evaluation process.